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## **Treatment as Usual? Experiences of a Postgraduate Nursing Student on an Acute Psychiatric Ward**

*Mental nursing is a bread and butter business, but there is not enough butter.*

JAH Ogdon (1947)

### **Abstract**

Nursing students are a rich source of fresh perspectives on mental health care. They often perceive a wide gap between theory and practice, and while their clinical placement experiences are mostly positive, they sometimes find a disillusioning lack of therapeutic engagement with patients on acute psychiatric wards. In this article, selections from a particularly insightful student's diary are presented, with commentary on the meaning of her experiences and the need for reform in acute psychiatric care.

### **Background**

Despite the shift of services to the community, inpatient settings remain an important component of the mental health system. Two persistent problems in acute psychiatric care are nurse recruitment, and the paucity of therapeutic engagement with patients. A study of newly-qualified nurses who completed a postgraduate diploma in mental health nursing (McCrae *et al*, 2014) showed that while acute wards had provided a good learning experience, they were not desirable places to work on qualification. These students, most of whom were psychology graduates, had consistently observed a higher quality of nursing staff in the community than in inpatient areas, where they often perceived mediocrity and minimal nurse-patient contact.

The large mental hospitals have closed, but acute psychiatric wards (typically situated in an annexe of a general infirmary) retain features of the 'total institution' described by sociologist Erving Goffman (1961). The *raison d'être* of the hospital observed by Goffman was subverted by the need for certainty and order, with boundaries enforced by nurses as a means of social distancing from their stigmatised patients. The seminal work of Hildegard Peplau (1988) emphasised interpersonal relationships as the vehicle of nursing, but studies in mental hospitals (e.g. John, 1961) revealed that nurses spent only around 10% of their shifts talking to patients, and Annie Altschul (1972) found nurses unable to articulate a purpose for such interactions. Altschul had major influence on mental health nurse training, highlighting therapeutic skills and problem-solving approaches. Yet the Chief Nursing Officer's review of mental health nursing *From Values to Action* (Department of Health, 2006) found little progress in the therapeutic activity of nurses in psychiatric admission units. A review by Sharac and colleagues (2010) of 13 studies measuring nurse-patient interaction in psychiatric wards showed that while nurses were involved with patients for an average of half of their shifts, such contact was mostly instrumental.

This therapeutic shortfall is attributable to a combination of constraints. Although patient contact should be the primary source of job satisfaction for nurses, the psychiatric system does not adequately support individualised care. As the number of beds has declined, the function of acute admission units has

necessarily been confined to containment and brief treatment, with the aim of minimising length of stay. Quirk and Lelliott (2001) argued that the organisational pressures of a permeable institution with rapid patient throughput and high staff turnover impairs the quality of care. Reduced hospital provision has led to a higher proportion of detained patients with severe mental disorder, and reliance on pharmacological treatments.

Handy (1991) explored how mental health nurses deal with the conflict between their caring and controlling functions. Interactions with patients were mostly related to ward routines, and the fewest with patients' personal problems; novice nurses were deterred from getting involved in the latter by the more experienced staff. Nurses appeared to derive comfort from maintaining order in an impersonal regime. This finding was in concordance with the classic study by psychoanalyst Isobel Menzies (1960), who explained how defence mechanisms such as denial of emotional involvement are unconsciously maintained by nurses to protect themselves from stress. Handy disagreed with nurses who attributed lack of therapeutic activity to staffing levels; the real issue, she argued, was the underlying discrepancy between the ideals of care and administrative efficiency. Until this conflict is resolved at organisational level, nurses would continue to avoid therapeutic engagement.

Research suggests that patients would like more time for individual sessions with nurses (Brimblecombe *et al*, 2007). However, reviewing studies of patients' expectations of mental health nursing in the UK, Bee and colleagues (2008) found nurses' inaccessibility to be a common complaint, as also found in a recent study by service-users (Rose *et al*, 2015). Moyle (2003) contrasted the close relationship desired by patients and the detached stance of nurses. While patients expected psychiatrists to focus on illness and symptoms, they did not want this from nurses. Moyle discussed how avoidance of contact leads to a lack of positive feedback, depriving nurses of the inherent satisfaction of caring. Nurses are prone to burnout, which correlates with the violence often experienced in psychiatric settings (Sullivan, 1993).

Unlike the scheduled work of psychologists, nurses cannot dedicate time for individual sessions due to the need to respond to incidents or admissions. Their therapeutic potential is not fully recognised by other disciplines. Clinical supervision is particularly important for staff dealing with challenging patients (Crowhurst & Bowers, 2002), but this is not always provided. Moreover, nurses may believe that people with serious mental illness are incapable of benefiting from therapeutic activity (Warne & McAndrew, 2014). Another obstacle is understaffing, and consequent reliance on agency workers who do not know the patients.

Recruits to nurse training often find acute wards very challenging, particularly in their early placements. Many students respond to adverse clinical placement experiences by taking a 'just passing through' attitude (Melia, 1982), their transient status enabling them to rationalise any doubts or concerns. For others, the culture of acute wards feels so oppressive that it has a profound impact on future career choices: students may look ahead to working in the community or in specialist

services, but most jobs for new registrants are in the hospital settings that they found objectionable (McCrae *et al*, 2014). The gap between the ideals of nursing as imagined at the outset and the harsh reality can be hard to accept, and inevitably newly-qualified nurses leave the profession. We have much to learn from students. The case study presented here is intended to contribute to theoretical understanding of the functioning of acute psychiatric wards, and to suggest a way forward in improving the experience of students, nurses and patients alike.

## **Method**

With support from the author as personal tutor, postgraduate nursing student Melanie kept a diary of observations on her first placement, at an acute psychiatric ward for male patients. This was in response to Melanie's concerns about what she observed, and consequent doubts about her choice of career. The diary was written in private and only shown to the author. Melanie did not come to mental health nursing completely naïve. After studying art and social sciences at university she worked for three years as a family support worker for a charity, supporting people with social and psychological problems. She had learned to build relationships with clients on trust. Nonetheless, she anticipated that it would be more difficult to work with acutely unwell psychiatric patients, and that the staff might be exposed to high emotional pressure.

For confidentiality pseudonyms have been used throughout (including the student), and any potentially identifiable details have been amended or deleted. This was not a planned research activity and was not submitted to an ethics committee. With permission from Melanie, abridged excerpts from the diary are presented here, followed by the author's commentary.

## **Melanie's observations**

On my first day I meet my mentor, busy mostly with running things behind the scenes, writing up reports for tribunals, bed-managing and finding staff to cover shifts. She spends little time on 'the floor', and consequently little time with patients, though she is allocated as care coordinator to three. On discussing my learning objectives for this placement, she explains: -

Nursing is about recording and passing on information - leave the psychology to the psychologists. Your number one role is to keep people safe. If everyone is alive at the end of your day then you are being a good nurse.

I spend the morning unaccompanied, introducing myself to patients. The nurses have been in their station for some time now, with two or three healthcare assistants in the 'day area'. The lack of stimulus on the ward is mind-numbing: for most of the day there is nothing for patients to do but pace the stark corridors, watch television or wait until half-past every hour when the doors are open to the courtyard for 'smoking time'. Many patients stay in their rooms, mostly dormitories for two or four men partitioned by flimsy curtains. They stare at the ceiling or listen to CDs on repeat. Twice a day there is a one-hour group activity, whereby three or four men are taken for exercise, to a cooking class or a therapy group. Some of these sessions were good outlets for

expression and interaction, such as music therapy, but with a total of twenty-four men on the ward, too few got a chance to participate.

One afternoon I join the psychology group. There are six of us: three patients, a trainee psychologist and Davina, the ward psychologist. I sit quietly with a pen and paper, and the workshop on positive thinking begins. In the circle are Trevor, a tall man of Caribbean origin who nods gently and stares at the floor; Vern, a rotund black British man in his 30s, with a jovial yet slightly vacant expression; and Saul, an East Ender of Italian descent in his 50s, who sits slumped in his chair, struggling to stay awake and sometimes breaking into phlegmy snoring. The trainee psychologist sits glowing, eyes fixed reverently on Davina, who explains: -

We are going to think about positivity and imagination today. We are going to consider how the way people with healthy minds get along is that they are able to say 'Yes' to challenges and opportunities that arise, rather than people with disturbed minds who cannot do this.

Opposite me, the trainee psychologist is still smiling and nodding. Davina turns to Trevor: 'What do you think about this?' Silence as everybody turns to him. Trevor, still staring at the floor, responds quietly: 'Yes. That sounds right'. Davina continues: 'Can you see that you were able to say 'Yes' to something today, to coming to this group?' 'Yes, I guess so', Trevor replies. Davina leans forward in her chair:

Today we are going to use the power of our imaginations to take us to a happy, safe place. To focus only on the positive in times of difficulty, finding a happy place can be like a medicine to combat depressive feelings...

Saul shifts abruptly in his armchair. His words are slurred and there is a thin line of spittle on his chin: -

Shall I tell you what I think? I feel like we aren't being helped. We are being sedated. Drug companies are making a lot of money from our hell.

His eyes search the faces in the room, seeking support but getting none. After a pregnant pause, Davina smiles and continues: -

Okay, but this afternoon, Saul, we are focusing on positive things not negative things. Isn't that right, Vern?

Vern looks startled at being addressed, and responds: 'That's right...' He reverts to staring at his shoes.

On the following morning I attend the ward round with consultant psychiatrist Dr Maurice, together with a newly qualified psychiatrist, the ward pharmacist and two staff nurses. These meetings are meant to occur every week with the aim of evaluating treatment and discussing care plans from the perspective of both staff and patients. Dr Maurice's presence on the ward is felt profoundly by

all patients, but he brushes past people without a word as he enters the meeting room.

I am finding a seat by the door when Vern comes in. He looks nervously around the table, and as I am closest to him, he smiles broadly and offers me his hand. 'Hello, Doctor,' he says to me. Dr Maurice remains seated, his facial expression blank. He gestures for the patient to take a seat, which Vern pulls out awkwardly. For the next few minutes Doctor Maurice outlines how long Vern has been on the ward and checks through his drug chart with the pharmacist. Then for the first time, he looks up at the man in front of him and asks: 'Why do you think you were brought here, Vern?' Vern folds and refolds an invisible piece of paper in his hands as he talks in fragments of his adverse housing situation, anxiety, loneliness, recurring nightmares, nausea and eventual nervous breakdown. Dr Maurice stops shuffling his papers and glancing over charts to interrupt: 'And what is the illness that you have?' Vern replies: 'Paranoid schizophrenia.' At this point, the nurse next to me seems to rouse and on a blank page she writes: 'Vern: paranoid schiz'. Vern, who is sitting directly next to her, sees the note. His eyes rest on the table for a moment.

Dr Maurice continues: 'Right. Paranoid schizophrenia. And why do you take your medication?' Vern stutters: 'Because...because of my moods, to make me get better...but the thing is...sometimes it makes my whole body feel tight, in my chest...' Dr Maurice again interrupts: 'Did you stop taking your medication at home? Why do you need to keep taking it?' Vern repeats: 'Because it's making me get better.' After a few minutes it became clear that Vern cannot hold himself in his seat any longer. As the door behind him closed, Dr Maurice turns to address me for the first time in my three weeks on the ward. In front of all the other staff in the room, he says: -

Just a word of advice. Do not shake these guys' hands, and do not smile so much. These men are psychotic. Many are sexually disinhibited. You do not know how they will take it - or what they will think of you.

He turns back to his papers. Everyone is silent. A procession of patients are seen, and in each case the dialogue is firmly focused on medication and its presumed impact on symptoms. The anxiety around forthcoming meetings with the consultant psychiatrist can be felt by talking with any of the patients.

One day I am in the corridor talking to Saul when the meeting room door swings open and Dr Maurice barrels past. Saul launches at him. 'Doctor! Do you care about people's feelings, Doctor? Do you care about anyone?' Doctor Maurice briefly looks back at him, then laughs and continues walking briskly. 'I hope so! What are you talking about?' He leaves through the glass door at the entrance to the ward, and closes it swiftly behind him. 'Bastard!' Saul yells after him. I ask Saul if he wants to sit somewhere and talk, he tells me:

When people don't speak to you in a normal way, give you respect, it makes you feel sort of inhuman. The Doctor, all he ever asks me is 'How are you feeling from 1-5' - He gets paid a lot for that.

At times the tension on the ward is palpable. Alarms ring frequently, staff run along corridors, chairs are thrown at windows. But the pervasive feeling is hopelessness. There are times when a nurse responds to a rude remark with patience, though all too often I witness no attempt to be compassionate. One afternoon, during a drama group workshop in the 'day area', a nurse sits watching us as we make shapes using our bodies to illustrate our chosen emotion. Mamoud asks several times for the garden to be open so that he can smoke. The nurse ignores him for a few minutes, then finally turns abruptly and exclaims: 'You need to shut up - just shut up'. I query this with another nurse, Sam, who tells me: -

You have to be careful what you say, and always assume the best of nurses... otherwise people won't want to work with you.

Hodi is a young man who is often animated and talkative, frequently asking questions. To most of the staff, he is seen as 'attention-seeking' or 'intrusive', two adjectives that regularly appear in his notes. Today he is calling Sam's name repeatedly. He calls through the glass of the nurse's booth, pokes his head through windows during meetings and attempts to speak with him in the hallway or during medication rounds. Curtains are drawn in front of Hodi's face. 'Not now, Hodi' is said too often. As he calls loudly in the corridor, Sam leans over to a bank nurse sat nearby and asks: -

Can you just give him 5mg of PRN Lorazepam please? He keeps calling my name.

A little while later, Hodi reappears in the hall. His eyes are noticeably heavy, his features drooping. 'Call my dad!' he slurs heavily through the glass booth, the words rolling around on his lethargic tongue. 'You have given me a drug without his permission!' I ask Sam what Hodi has been given. 'It's a sedative,' he explains calmly. 'He needs to sleep; he hasn't slept in 24 hours.' My mind is spinning as I choose my words carefully. 'You want him to sleep in the daytime?' Sam turns to Hodi: 'You need to go to sleep! You'll feel much better!' He turns back to his computer. 'That would be great if he slept in the daytime' he muttered.

On another occasion Hodi walks out of the 'day area' with a bowl of cake and custard in his hand. He comes over to the clinic room door and speaks over the head of another patient taking his medication, 'Can I have some paracetamol?' he asks loudly. Nurse Leroy stiffens: 'You can't walk around with that food! Go and sit down and stop getting in everyone's way!' he shouts. Hodi, surprised by Leroy's tone of voice, raises his voice, 'I just want a paracetamol. Then I'll eat it. Why are you shouting at me?' Leroy leans out the hatch in the door, his voice low, 'Go and do as you are told or I'll give you something other than paracetamol.' A healthcare assistant attempts to steer Hodi away, but he turns back and shouts 'What? Is that a threat! Yeah? I have rights, you dickhead! I'm not taking anything you give me!' Leroy is unflustered. 'You know you will have to take it if you get angry. I can make you take it'. As Hodi starts towards Leroy I step in front of him and call his name. He lets me take his arm and guide him back to the 'day area' with his pudding.

The first time I meet Rashid he is pondering about why he is there. As a young Muslim man with a beard and a penchant for carrying a Koran under his arm, he had become increasingly anxious after the Paris bombings about being attacked. He tells me that he had been brought in by the police after they had found him walking the streets without any shoes, reading the Koran and weeping. He has been treated for several days with sleeping medication. An articulate man, Rashid is calm but clearly frustrated by what he sees around him.

People in England - white people - they go off to Africa to help people, but look here! All around are people who need care. But off they go, all the caring people, and what we are left with are people who are just thinking about having a job, a career, money. They aren't really caring for us.

Rashid is called to have his medication; he repeatedly says he does not want it. As nurses crowd around him, trying to persuade him to take the pills, he starts shouting that he doesn't trust any of them, and that they mustn't touch him. One nurse pulls an alarm and as the sirens sound, Rashid is taken into the clinic room, the curtains are drawn around him, and when a sizable nurse from another ward arrives as backup, Rashid is given a rapid tranquillising injection by force.

Later, Rashid and I are talking. He is preparing for a tribunal. His father, a highly educated man, is suspicious of the doctor's diagnosis and wants his son discharged as soon as possible. He tells Rashid to cooperate, as 'that is the only way we can get you out'. Rashid has just come out of a meeting where he was told that he would need to take medication for at least a year after leaving hospital. He is incredulous. 'What's the best way to get out of here?' he asks. I cannot answer this, but with the help of a lawyer and a mental health advocate, Rashid is released by tribunal two days later. He takes a bag full of medication and an appointment with the psychiatrist a week ahead. Hodi watches him go, and tells me: -

Some people do it right, they know that all you have to do is co-operate and they will let you out. Just don't argue with the doctors.

Sadly, the experiences I have recounted are not unique. Talking to colleagues and tutors, the reaction is not disbelief but solemn recognition. If what I have witnessed is 'normal' practice, or perhaps as I've been told, not quite bad *enough* to issue a formal complaint, how can we make this change? Once we begin to feel that the system as a whole is at fault, then we have a formidable mountain to climb. On a micro-level, what does seem evident is that somewhere and somehow along the line staff have stopped *feeling*. And to feel is necessary to understand and respond. If we stop looking for a narrative, if we work from a pathology framework, then a person with all their history and context becomes merely dysfunctional and diseased, 'other' than from ourselves. The story, the only thing that can make sense of a crisis, becomes irrelevant. It is trauma upon trauma.

Friends ask why I want to be a mental health nurse: 'Why don't you become a therapist, or a psychologist?' I struggle to answer. The role of the nurse is



heartbreakingly unclear: medication dispenser? Rule enforcer? Observer? Therapeutic agent? From my observations, probably not the last. What keeps me on this course is my belief that the core work is in the therapeutic relationship. And that can only occur when you spend real time with people throughout the day.

## **Commentary**

To any reader unacquainted with acute psychiatric wards, Melanie's observations and insights may be disturbing. The ward atmosphere seemed to be a product of the staff pursuit of order and the unrequited needs of patients: it is mostly calm and contained, but there is persistent underlying tension, which frequently erupts in desperate quests for attention and sometimes acts of aggression. The patients are bored, locked into a ward where treatment is rarely what they would have chosen for themselves. The instances that Melanie describes are not extreme or unusual to nurses who have worked in such settings; indeed, it is their ordinariness that makes them so illuminating.

This case study is not merely intended as an *exposé*, or to condemn bad practice. Members of staff are not deliberately stifling the therapeutic potential of the ward, but they are stuck in a system that reinforces conformity to institutional goals. A useful conceptual framework for understanding the flawed interaction between staff and patients is the Six-Category Intervention model of John Heron (2001). Heron emphasised the intent of the helper, rather than the outcome for the person seeking help. In his formulation there are six forms of therapeutic intervention, which are either authoritative or facilitative: in the former the interventions are prescriptive, informative or confronting; in the latter they are cathartic, catalytic or supporting.

Heron also described degenerate forms of these interventions, which may be attributed to the helper's lack of experience or self-awareness. Such activity has therapeutic purpose but actually has the reverse effect. The psychology group would not be out of place in a Will Self novel; the intention is clear, yet there is a supportive degeneration in that patients must first accept that their thoughts and behaviour are negative. Support is qualified: the good patient follows the therapist's way to a positive outlook. Perhaps this is the easiest means of reward in a medically-dominated regime, whereby mind is of lesser import to body in a dualism shaped by professional power.

Prescriptive degeneration (Heron, 2001) is widely evident in Melanie's account. Dependency is created in a system that makes all the decisions, with patients' leave or discharge conditional to their acceptance of the treatment plan and the rules of the ward. The medical model is often a parody in critical nursing literature, but here it seems real and dominant, with a treatment regime that is primarily pharmacological. Despite professional lip service to working in partnership, patients are kept on the lowest rung of the hierarchy; applying Berne's (1964) transactional analysis, they are encouraged to accept child status, overlooked by the parent staff. As in *One Flew over the Cuckoo's Nest* (Kesey, 1963), nurses are bossy and apply a behaviourist approach, thereby taking the role of critical parent.

It must be acknowledged that the work of the nurse in acute psychiatric wards

is stressful and underappreciated. Most nurses come to the profession with a genuine desire to help people, but this motive may be blunted by exposure to high workload pressure and institutional demands that conflict with individualised care. Compassion is overshadowed by the three Cs of the role: clerical, clinical and custodial. Instead of spending their shifts talking to patients, as a naïve outsider might reasonably expect, some nurses blatantly convey their detachment. Signs of Goffman's 'total institution' are here, with social distancing through depersonalising language such as the 'day area' for the lounge, 'lockers' for bedside cabinets, and 'dormitories' for the bedrooms. Although nurses, doctors and other clinicians are working hard, patients' satisfaction seems to be an unaffordable luxury, as Yawar (2008) argued: -

There are countless humane, imaginative and gifted clinicians working in psychiatric hospitals. But below certain levels of funding, staffing, stability and expertise, psychiatric hospitals come to embody the opposite of their aim, becoming dingy and brutal, and fostering permanent disability and stigma.

Limitations of this case study should be considered. It presents a one-sided view, from an idealistic perspective. Despite an unsustainably pressurised system that teeters towards crisis, most nursing students adapt to the adversity and move on in their training. Such adjustment may be more difficult for students who come to nursing influenced by critical psychiatry literature. Foucault (1967) does not provide any practical solutions to patients' problems; his sceptical analysis does not tell us how to keep patients safe from harm, or how to alleviate the severe mental disturbance of psychosis or mania. Students like Melanie are troubled by powers that nurses are given for good reason: patients are detained for the safety of themselves and others, and sometimes a forced injection may be necessary. Nonetheless, students may have valid criticisms of the manner in which these powers are applied. Heron's (2001) framework helps students to understand the need for control, on the condition that actions are intended for therapeutic benefit, and not for staff convenience.

## **Conclusion**

Therapeutic engagement is sorely lacking in Melanie's account. Yet such contact is mutually beneficial to patients (providing emotional support and facilitating recovery) and to nurses, who may be rewarded by role fulfilment. The author is currently leading research on developing the therapeutic role of the nurse in acute psychiatric care, and this relies on collaboration. As Rose and colleagues (2015) asserted, service-user involvement is indispensable in research on the running of acute psychiatric wards. Students may be seen as a bridge between patients and staff, and their fresh perspectives are of great value towards reform of wards that admit people at their lowest ebb.

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